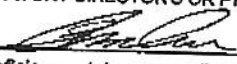


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Investigation of Complaints #26807, #27570, #25428 and #26535 were completed with the annual Recertification survey conducted February 28 through March 2, 2011, at The Bridge At South Pittsburg. No deficiencies were cited in relation to Complaints #26807, #27570 and #25428 under 42 CFR Part 483, Requirements for Long Term Care Facilities. Federal deficiencies were cited in relation to complaint #26535.	F 000	Disclaimer: The Bridge at South Pittsburg does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 			TITLE Administrator		(X6) DATE 3/21/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation and interview, the facility failed to notify the resident's physician/nurse practitioner of increased pain after a fall resulting in a fractured hip for one (#9) of twenty-six residents reviewed. The facility's failure resulted in harm for resident #9.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on January 15, 2010, with diagnoses including Vitamin B12 Deficiency, Cerebral Atherosclerosis, Vascular Dementia, Insomnia and Anxiety.</p> <p>Review of the Minimum Data Set dated October 13, 2010, revealed the resident had difficulty with long and short term memory, and had impaired decision making skills.</p> <p>Review of facility documentation dated November 14, 2010, at 7:45 p.m., revealed the resident sustained a fall, resulting in a fracture of the right hip. Review of the nursing notes dated November 14, 2010, at 7:45 p.m., revealed the nurse, who assessed the resident after the fall, documented "...Pt. (Patient) does complain of (R) (right) inner thigh hurting..." Medical record review revealed there was no documentation the nurse offered the resident pain medication, or notified the Nurse Practitioner (NP)/Medical</p>	F 157	<p>F 157 NOTIFY OF CHANGES, (INJURY, DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status</p> <p>Residents affected: Resident #9 was assessed for pain and sent to the ER for evaluation. Resident #9's MD/NP was notified.</p> <p>Residents potentially affected: All Residents have the potential to be affected by the cited practice. Med carts and MAR'S were audited and licensed staff were in-serviced on pain protocol and physician notification by the SDC. SDC/Designee will educate all new hires on pain protocol and physician notification. Staff will be educated that if pain is present, and not relieved by current regime, MD/NP will be notified upon assessment and new orders received.</p> <p>Systemic measures: Residents with new orders for pain medication will be reviewed throughout the week in our clinical meeting and discussed weekly in our at risk meeting. Facility E-kits revised based on utilization. The DON/Designee will validate pain medication orders compared to the MAR and to the med cart and notification of MD/NP throughout the week.</p> <p>Monitoring measures: DON/Designee will review orders for pain medication and proper documentation throughout the week and in the at risk meeting x 8 weeks. Any concerns will be addressed immediately and staff re-educated. Identified concerns will be addressed in monthly QA.</p>	3/31/2011	

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BRIDGE AT SOUTH PITTSBURG, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

201 EAST 10TH STREET

SOUTH PITTSBURG, TN 37380

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F 157	<p>Continued From page 2</p> <p>Doctor (MD) of the resident's pain from November 14 until November 16, 2010.</p> <p>Review of the nursing notes dated November 15, 2010, at 11:00 a.m., revealed, "...Pt. (patient) cont. (continues) to c/o (complain) pain mainly in (R) hip..." Medical record review revealed no documentation the nurse offered the resident pain medication or notified the NP/MD of the resident's complaint(s) of pain from November 14, until November 16, 2010.</p> <p>Continued review of the documentation revealed the NP was notified and ordered an x-ray, which was completed on November 15, 2010, with "...Findings strongly raise suspicion of a subcapital fracture of the right proximal femur...No acute displaced fractures...CT scan (Computerized Tomography scan) would be helpful to confirm or deny a fracture of the right subcapital region..."</p> <p>Review of the hospital documentation revealed the resident was transferred to the hospital on November 16, 2010 for a CT scan of the right hip, due to "...increased pain described by the patient as 'sharp'..." Continued review of the hospital documentation dated November 16, 2010, revealed the patient rated the pain as "...the worst pain ever..." Review of the results of the CT scan revealed "...Acute Impacted Right Femoral Neck Fracture with some 90 degrees of Varus Angulation and Posterior Rotation of the Femoral Diaphysis..."</p> <p>Interview with Licensed Practical Nurse #3 on March 2, 2011, at 11:45 a.m., in the Training Room, confirmed the resident had increased pain</p>	F 157		

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F 157	Continued From page 3 with activities of daily living, bathing, moving, transfers, etc. after the fall on November 14, 2010. Continued interview confirmed on November 15, 2010, the resident had "continued to complain of pain" and the Nurse (LPN #3) failed to notify the NP of the resident's initial pain which began on November 14, 2010 or continued pain, as documented in the nurse's notes on November 15, 2010. Interview with the Administrator In Training (AIT) on March 2, 2011, at 3:45 p.m., in the Training Room confirmed the NP or MD was not notified of the resident's pain and/or increased pain from November 14, 2010, after the fall, until November 16, 2010. Interview with the NP on March 2, 2011, at 4:00 p.m., in the Training Room confirmed the nurse(s) did not notify the NP of the resident's pain after the fall, and failed to notify the NP of the resident's increased pain prior to going to the hospital for the CT scan. Continued interview with the NP confirmed the NP was the person to be notified for medication orders related to new onset or increased pain because the NP was present in the facility five days a week, on call at night on alternate weekends.	F 157		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and	F 253	F 253 HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Residents Affected: Resident # 12 bathroom floor was replaced with new flooring. The shower tile was cleaned in the central bath on unit 2. Residents potentially affected: All residents have the potential to be affected by this cited practice. Housekeeping supervisor/designee will report identified environmental concerns in morning meeting. Systemic Measures: Department heads will perform walking rounds through-out the work week and report environmental concerns in morning meeting. The identified concerns will be addressed immediately and follow-up on by the Housekeeping supervisor/designee. Monitoring Changes: Housekeeping supervisor will maintain a log of identified environmental concerns and follow-up. Areas of concerns will be addressed in monthly QA.	3/31/2011

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F 253	<p>Continued From page 4</p> <p>Interview, the facility failed to provide a clean, sanitary environment in one shower room of three shower rooms observed, and one resident's (#12) bathroom of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Observation with the House Supervisor during the initial facility tour on February 28, 2011, at 10:10 a.m., in the central shower room on the 200 hall, revealed a black substance on the grout line of multiple tiles on the shower wall and around the top of the tile at the base of the shower.</p> <p>Interview with the House Supervisor on March 1, 2011, at 9:30 a.m., at the 200 hall nurses station confirmed the black substance appeared to have been mold, and had been removed from the shower room wall.</p> <p>Resident #12 was admitted to the facility on January 4, 2011, with diagnosis including Chronic Kidney Disease, Stage 3, Altered Mental Status, Dehydration, Anemia, Advanced Alzheimer's disease, Multiple Myeloma, and History of Cerebrovascular Accident.</p> <p>Observation on February 28, 2011, at 9:45 a.m., with the Director of Nursing (DON), revealed the resident out of bed sitting in a wheel chair. Continued observation of the resident's room revealed a significant, foul, urine odor in the room. Continued observation of the resident revealed the resident stated to the DON, "...You gotta do something with that bathroom ..."</p> <p>Continued observation of the resident's bathroom revealed a strong, foul, urine odor in the bathroom, also.</p>	F 253			

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NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380		
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F 253	Continued From page 5 Interview with the Director of Nursing on February 28, 2011, at 9:45 a.m., in the hall near the resident's room revealed the resident voided on the floor in the room and on the floor and wall of the bathroom. Continued interview revealed the resident was incontinent of bladder; however, the resident wore a brief and would pull the brief down to void. Observation with the housekeeper (#1) on March 1, 2011, at 4:00 p.m., in the resident's room confirmed the housekeeping staff cleaned the room on a routine basis. Continued observation with the housekeeper revealed the bathroom floor had moisture between the cracks in the flooring when the foot was placed firmly on the floor. Interview with the administrator on March 1, 2011; at 4:15 p.m., in the resident's room, confirmed the room had a foul, urine odor, and the flooring needed to be replaced.	F 253	F278 ASSESSMENT ACCURACY, COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. Resident affected: Resident # 24 is a closed record. Resident potentially affected: All residents have the potential to be affected by this cited practice. Resident's weights were reviewed for accuracy and documentation. Systemic measures: The interdisciplinary team will review resident MDS assessments during the weekly at risk meeting for accuracy as it relates to weight variances. Monitoring changes: The interdisciplinary team will document discrepancies in weights and report identified changes to the MDS coordinator and DON/designee. Identified weight changes will be reviewed weekly x 4 weeks and then monthly x 2 months. Any concerns will be addressed and reported to QA monthly.	3/31/2011	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278			

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SOUTH PITTSBURG, TN 37380

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F 278	<p>Continued From page 8</p> <p>willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure an accurate MDS 2.0 (Minimum Data Set version 2.0) assessment for one resident (#24) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident #24 was admitted to the facility on June 14, 2010, with diagnoses including Vascular Dementia and Hypertension.</p> <p>Medical record review of the MDS 2.0 dated August 4, 2010, revealed the resident had a weight gain that would be defined as 5% (percent) or more in the last 30 days or 10% or more in the last 180 days.</p> <p>Medical record review of the Monthly/Weekly Weight Recap Sheet revealed the following documented weights: Admit=167 (weight in pounds); week 3 of June, 2010=167; week 4 of June, 2010=162.5; week 1 of July, 2010=157 with</p>	F 278		

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F 278	Continued From page 7 a re-weigh of 158, resulting in a 5.39% weight loss; week 2 of July, 2010=160; week 3 of July, 2010=159; and week 1 of August, 2010=154. Interview with the MDS nurse on March 2, 2011, at 10:15 a.m., in the Training Room, confirmed the resident had experienced a weight loss, not a weight gain, and the MDS assessment was inaccurate.	F 278			
F 280 SS=D	C/O #26535 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment. Residents affected: Residents #1, #12, and #17's care plans were updated to reflect their current plan of care. Resident #1's foley catheter was d/c'd. Resident #12 was referred to social/psych services. Resident #17 was assessed for safe use of the motorized wheelchair Residents Potentially Affected: All residents have the potential to be affected by this cited practice. Residents with motorized wheelchairs, foley catheters and urinating on floor were care planned. Systemic measures: DON/Designee will review care plans in coordination with the MDS schedule throughout the week to verify accuracy of the plan of care x4 weeks; bi-weekly x 4 weeks. The SDC will coach and mentor the MDS coordinator and care plan coordinator on concerns identified. Monitoring changes: The SDC will report any identified areas to the DON/Designee and education provided to the MDS Coordinator/care plan coordinator for follow-up as indicated. Results will be reported in monthly QA meeting.	3/31/2011	

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F 280	<p>Continued From page 8</p> <p>review, observation and interview, the facility failed to update the care plan for three residents (#1, #12, and #17) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on December 9, 2010, with a diagnosis of Alzheimer's Dementia, and was re-admitted to the facility on February 17, 2011, with an additional diagnosis of Status Post ORIF (Open Reduction Internal Fixation) Left Hip related to a fracture of the left hip.</p> <p>Medical record review of the Minimum Data Set dated December 15, 2010, revealed the resident required limited assistance with transfers and ambulation, did not have an indwelling catheter, and was continent of bowel and bladder.</p> <p>Observation of the resident on March 1, 2011, at 10:10 a.m., and interview with PT (physical therapist) #1, in the therapy department, confirmed the resident was in a wheelchair and receiving physical therapy following the hip fracture. Continued observation and interview confirmed the resident had been continent and independent in ambulation prior to the hip fracture, but currently had an indwelling catheter, could not maintain weight bearing status, and needed the assistance of two for transfers. Continued interview confirmed the resident had staples intact to the surgical incision in the left hip.</p> <p>Medical record review of the resident's care plan revealed the last update to the care plan was January 19, 2011. Further review of the care plan</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>revealed the resident was discharged from therapy, was unsteady in gait, had opportunity to progress in the facility and would be seen by restorative therapy. Further review of the care plan revealed it did not address the indwelling catheter, indicated the resident was usually continent of urine, and did not address the hip fracture, staples, or surgical incision.</p> <p>Interview with the Director of Nursing (DON) and Administrator In Training on March 1, 2011, at 10:40 a.m., on Station 1, and with the DON on March 2, 2011, at 9:20 a.m., in the Training Room, confirmed the care plan had not been updated to reflect any changes in the residents functional status since the hip fracture and surgery.</p> <p>Resident #12 was admitted to the facility on January 4, 2011, with diagnoses including Chronic Kidney Disease, Stage 3, Altered Mental Status, Dehydration, Anemia, Advanced Alzheimer's disease, Multiple Myeloma, and History of Cerebrovascular Accident.</p> <p>Interview with the Director of Nursing on February 28, 2011, at 9:45 a.m., in the hall near the resident's room revealed the resident voided on the floor in the room and the wall and floor of the bathroom. Continued interview with the DON revealed the resident was incontinent of bladder; however, the resident wore a brief and would pull the brief down to void.</p> <p>Interview with the Director of Nursing on March 1, 2011, at 5:00 p.m., in the Training room, confirmed the resident had not been care planned for the problem of voiding on the floor and on the wall.</p>	F 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page 10 Resident #17 was admitted to the facility on February 5, 2002, with diagnoses including Late Effects of Cerebrovascular Accident, Flaccid Hemiplegia, Diabetes Mellitus, and Obesity. Medical record review of the Minimum Data Set dated February 1, 2010, revealed the resident had short term memory impairment, and required assistance with decision making. Continued review revealed the resident required maximum assistance with transfers, and was non-ambulatory. Review of the therapy discharge summary dated December 8, 2010, revealed, "...Power wheelchair safety assessment was completed and patient demonstrated good safety with use of power wheelchair..." Review of the facility policy, Wheelchairs - Use of Non-Motorized, Motorized, revealed, "...Residents utilizing wheelchairs and motorized wheelchairs will be assessed through the MDS (Minimum Data Set) process regarding their motor and cognitive skills to safely operate the wheelchairs. Their capability should be assessed, careplanned, and discussed with the resident and/or responsible party. Residents will also be assessed utilizing wheelchair assessment tools for motorized or non-motorized wheelchairs..." Review of the resident's care plan dated April 23, 2010, revealed no documentation the resident had been assessed for the safe use of the powerchair (i.e. electric or motorized wheelchair.) Interview with the Director of Nursing in the director's office on March 2, 2011, at 8:35 a.m.,	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER

BRIDGE AT SOUTH PITTSBURG, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

201 EAST 10TH STREET

SOUTH PITTSBURG, TN 37380

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F 280	Continued From page 11 confirmed the resident's care plan had not been revised to include the safe use of the power chair.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to assess/provide pain management interventions after a hip fracture for one (#9) of twenty-six residents reviewed resulting in unresolved pain and harm for resident #9. The findings included: Resident #9 was admitted to the facility on January 15, 2010, with diagnoses including Vitamin B12 Deficiency, Cerebral Atherosclerosis, Vascular Dementia, Insomnia and Anxiety. Review of the Minimum Data Set dated October 13, 2010, revealed the resident had impaired decision making skills. Review of the Nurse Practitioner's (NP) orders dated November 9, 2010, revealed, "...Lortab 2.5/500 mg. (Milligrams) p.o. (by mouth) (for abdominal discomfort)...D/C (discontinue) Tylenol BID (two times a day) when Lortab available..."	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Residents affected: Resident #9 was assessed for pain and sent to the ER for evaluation. Residents potentially affected: All Residents have the potential to be affected by the cited practice. Med carts and MAR'S were audited and licensed staff in-serviced on pain protocol and physician notification. SDC/Designee will educate all new hires on pain protocol and physician notification. Staff will be educated that if pain is present, and not relieved by current regime, MD/NP will be notified upon assessment and new orders received. Staff will also be educated on reassessing resident's pain at appropriate intervals based on medication regimen and resident symptoms. Systemic measures: Residents with new orders for pain medication will be reviewed throughout the week in our clinical meeting and discussed weekly in our at risk meeting. E-Kits were reviewed for appropriate pain medications. The DON/Designee will compare the MAR to the order and verify MD/NP notification of pain upon assessment with nursing oversight. Monitoring change: DON/Designee will review orders for pain medication and proper documentation throughout the week and in the at risk meeting x 4 weeks then monthly. Concerns will be addressed immediately and staff re-educated and reported in monthly QA.	3/31/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 12 Review of the Medication Record for November 2010 revealed the resident received the Tylenol 650 mg. two times a day as ordered through November 15, 2010. Continued review of the November 2010 Medication Record revealed the resident did not receive the Lortab 2.5 mg. as ordered from November 9, thru November 15, 2010, as indicated by an "X" or by the nurse signing and circling the times as "not administered" to the resident. Continued review of the back of the Medication Record revealed no documentation why the Lortab was not administered on November 9, 10, or 11, 2010 (spaces were left blank). Continued review of the Medication Record, revealed on November 12, 13, 14, & 15th, the nurses documented "...Lortab not available-Pharmacy notified..." Continued review of the Medication Record for November 2010 revealed the resident received the first dose of Lortab 2.5/500 mg. on November 16, 2010 at 8:00 a.m., a delay of six days. Review of facility documentation dated November 14, 2010, at 7:45 p.m., revealed the resident sustained a fall resulting in a fracture of the right hip. Continued review of the documentation revealed the (NP) was notified and ordered an x-ray, which was completed on November 15, 2010, with a diagnosis of: "...Findings strongly raise suspicion of a subcapital fracture of the right proximal femur...No acute displaced fractures...CT scan (Computerized Tomography scan) would be helpful to confirm or deny a fracture of the right subcapital region..." Review of the nursing notes dated November 14, 2010, at 7:45 p.m., revealed the nurse, who assessed the resident after the fall, documented "	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 309	<p>Continued From page 13</p> <p>...Pt. (Patient) does complain of (R) (right) inner thigh hurting ..." Medical record review revealed no documentation the nurse offered the resident pain medication, or notified the NP/Medical Doctor (MD) of the resident's pain for any of the shifts until November 16, 2010.</p> <p>Review of the nursing notes dated November 15, 2010, at 11:00 a.m., revealed, "...Pt. (patient) cont. (continues) to c/o (complain) pain mainly in (R) hip..." Medical record revealed no documentation the nurse offered the resident pain medication or notified the NP/MD of the resident's complaint(s) of pain from November 14, 2010, (at the time of the fall) until November 16, 2010, on all shifts.</p> <p>Review of the hospital documentation dated November 16, 2010, revealed the resident returned to the hospital on November 16, 2010 for a CT scan of the right hip, due to "...increased pain described by the patient as 'sharp'..." Continued review of the hospital documentation dated November 16, 2010, revealed the patient rated the pain as "...the worst pain ever..." Review of the results of the CT scan revealed "...Acute Impacted Right Femoral Neck Fracture with some 90 degrees of Varus Angulation and Posterior Rotation of the Femoral Diaphysis..."</p> <p>Review of the Medication Record dated November 2010, revealed on November 16, 2010, the NP increased the Lortab from 2.5/500 mg. BID to 5/500 mg. BID, due to increased pain in the right hip, (two days after the resident's fall).</p> <p>Observation on February 28, 2011, at 3:45 p.m., revealed the resident lying on a low bed, one mat on the floor at bedside, one side of the bed</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 14 pushed against the wall.</p> <p>Interview with Licensed Practical Nurse (LPN #3) on March 2, 2011, at 11:45 a.m., in the Training Room, confirmed the resident had increased pain with activities of daily living, bathing, moving, transfers, etc. after the fall. Continued interview confirmed on November 15, 2010, the resident had "continued to complain of pain" and LPN #3 did not offer the resident pain medication and failed to notify the NP of the resident's initial pain which began on November 14, 2010, or continued pain until November 16, 2010.</p> <p>Interview with the Administrator In Training (AIT) on March 2, 2011, at 3:45 p.m., in the Training Room confirmed the resident was not offered Lortab 2.5/500 mg. for increased pain after a fall; the facility failed to provide any interventions to manage resident #9's pain; the Nurse Practitioner or Doctor was not notified of the resident's pain or of the resident's increased pain; and the nurse(s) did not notify the NP that the Lortab 2.5/500 mg. was not available.</p> <p>Interview with the NP on March 2, 2011, at 4:00 p.m., in the conference room confirmed the nurses did not notify the NP of the resident's pain after the fall; and of the resident's increased pain prior to going to the hospital for the CT scan; or that the Lortab 2.5/500 mg. was not available and had not been administered as ordered. Continued interview confirmed if the nurses had notified the NP of the resident's pain, or that the Lortab 2.5 mg. was not available the NP would have ordered another pain medication. Further interview confirmed the NP was the person to be notified for medication orders related to new</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 309	Continued From page 15 onset or increased pain, the NP was present in the facility five days a week, on call at night on alternate weekends.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility's Roster/Sample Matrix, observation and interview, the facility failed to obtain a physician's order or assess for the need of an indwelling catheter for one resident (#1) of twenty-six residents reviewed. The findings included: Resident #1 was admitted to the facility on December 9, 2010, with a diagnosis of Alzheimer's Dementia, and was re-admitted to the facility on February 17, 2011, with an additional diagnosis of Status Post ORIF (Open Reduction Internal Fixation) Left Hip due to a fracture of the left hip. Medical record review of the Minimum Data Set dated December 15, 2010, revealed the resident	F 315	F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not a catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. Resident affected: Resident #1 foley catheter was removed. Residents potentially affected: All residents with foley catheters have the potential to be affected by this cited practice. Residents with foley catheters were assessed for orders and supporting diagnoses. Systemic Measures: DON/Designee will review physician orders throughout the week for accuracy and appropriate diagnoses. Licensed nurses will be educated on the protocol for foley catheters. The Infection Control nurse will review (re)admissions and current residents, who have a foley catheter, for appropriate documentation. Monitoring change: DON/Designee will review residents with foley catheter orders. The DON/Designee will complete the QA audit tool for residents identified with catheters weekly x4 weeks and monthly thereafter. Results will be reviewed monthly in QA.	3/31/2011	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	<p>Continued From page 16</p> <p>required limited assistance with transfers and ambulation, did not have an indwelling catheter, and was continent of bladder.</p> <p>Review of the facility's Roster/Sample Matrix updated February 28, 2011, revealed the facility had two residents with indwelling catheters, and resident #1 did not have an indwelling catheter.</p> <p>Observation of the resident on February 28, 2011, at 10:05 a.m., 1:40 p.m., and 3:10 p.m., and on March 1, 2010, at 7:25 a.m., 8:35 a.m., and 12:35 p.m., revealed the resident in bed with an indwelling catheter present.</p> <p>Observation of the resident on March 1, 2010, at 10:10 a.m., and interview with PT (physical therapist) #1, in the therapy department, confirmed the resident was in a wheelchair and receiving physical therapy following the hip fracture. Continued observation and interview confirmed the resident had an indwelling catheter and had been continent of urine and independent in ambulation prior to the hip fracture.</p> <p>Medical record review of the physician's orders revealed no order for the indwelling catheter.</p> <p>Medical record review of the resident's care plan revealed the last update to the care plan was January 19, 2011; the care plan did not address the indwelling catheter, and stated the resident was usually continent of urine.</p> <p>Medical record review of the resident assessments revealed the Bowel and Bladder assessment was completed December 23, 2010, and indicated the resident was continent of bowel and bladder and did not have an indwelling</p>	F 315		

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F 315	Continued From page 17 catheter. Further medical record review revealed no documentation the resident had an indwelling catheter and no assessment to justify the need for an indwelling catheter.	F 315			
F 323 SS=D	Interview with the Director of Nursing (DON) and Administrator In Training on March 1, 2011, at 10:40 a.m., on Station 1, and with the DON on March 2, 2011, at 9:20 a.m., in the Training Room, confirmed the facility did not have a physician's order, assessment, or care plan for the indwelling catheter. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical review, observation, facility policy review, and interview, the facility failed to provide supervision to prevent accidents for one resident (#13) with an inactivated bed alarm, and one resident (#17) who had not been reevaluated for safe powerchair operation. The findings included: Resident #13 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Status Post Surgery, Acute	F 323	F 323 FREE OF ACCIDENT/HAZARDS, SUPERVISION/DEVICES The facility must ensure resident environment remains as free from accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents. Residents affected: Resident #13 was assessed and the alarm was replaced. Resident #17 was assessed for safe use of a motorized wheelchair. Residents potentially affected: All residents have potential to be affected by this cited practice. Staff were educated regarding use of alarms and safe use of motorized wheelchairs. Systemic measures: Central Supply will validate alarms are turned on throughout the week and report findings to DON/Designee. All residents using motorized wheelchairs will be assessed upon admission, quarterly, or PRN for the safe use of their motorized wheelchairs and assessment of alarms. Monitoring change: Central Supply will immediately correct any alarm that wasn't turned on and findings reported to DON/Designee throughout the work week. DON/Designee will notify therapy dept when a resident uses a motorized wheelchair and an assessment will be completed. The therapy dept will assess motorized wheelchairs on admission, quarterly and PRN. Residents whom are deemed unsafe or alarms not on will be reported to the DON/Designee and addressed in monthly QA.	3/31/2011	

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F 323	<p>Continued From page 18</p> <p>Venous Embolism & Thrombosis, Alzheimer's disease, Essential Hypertension, and Atrial Fibrillation.</p> <p>Review of the Fall Risk Assessment dated February 17, 2011, revealed the score was 24 or High risk for falls.</p> <p>Review of the facility documentation dated February 22, 2011; revealed the resident sustained a fall with no injuries. Continued review of the documentation revealed a bed alarm was put in place at that time.</p> <p>Observation on February 28, 2011, at 9:30 a.m., revealed the resident in a low bed, pushed against the wall, with a safety mat on the floor. Continued observation with the Director of Nursing (DON) at the same time revealed the bed alarm in place (under the resident), not turned on (not operating).</p> <p>Interview with the DON on February 28, 2011, at 9:35 a.m., in the resident's room, confirmed the alarm was not activated.</p> <p>Resident #17 was admitted to the facility on February 5, 2002, with diagnoses including Late Effects of Cerebrovascular Accident, Flaccid Hemiplegia, Diabetes Mellitus, and Obesity.</p> <p>Medical record review of the Minimum Data Set dated February 1, 2010, revealed the resident had short term memory impairment, and required assistance with decision making. Continued review revealed the resident required maximum assistance with transfers, and was non-ambulatory.</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>Review of the physical therapy discharge summary dated December 8, 2010, revealed, "...Power wheelchair safety assessment was completed and patient demonstrated good safety with use of power wheelchair..."</p> <p>Review of the facility's documentation dated February 17, 2011, revealed resident #17 ran over another resident's foot with the power chair, and caused a skin tear to the lower left leg of the other resident.</p> <p>Continued review of the facility's documents revealed no documentation resident #17 had been reevaluated for the safe use of the power chair after February 17, 2011.</p> <p>Review of the facility policy, Wheelchairs - Use of Non-Motorized, Motorized, revealed, "...Residents utilizing wheelchairs and motorized wheelchairs will be assessed through the MDS (Minimum Data Set) process regarding their motor and cognitive skills to safely operate the wheelchairs. Their capability should be assessed, careplanned, and discussed with the resident and/or responsible party. Residents will also be assessed utilizing wheelchair assessment tools for motorized or non-motorized wheelchairs..."</p> <p>Interview with the Rehab (Rehabilitation) Services Manager on March 2, 2011, at 8:30 a.m., in the office of the Director of Nursing, confirmed residents are assessed for wheelchair safety annually, quarterly, and on a case-by-case basis as needed including after incidents. Continued interview confirmed resident #17 had not been reevaluated for the continued safe use of the power chair after the incident with the other resident.</p>	F 323		

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F 323	Continued From page 20 Interview with the Director of Nursing in the director's office on March 2, 2011, at 8:35 a.m., confirmed resident #17 had not been reevaluated for the safe use of the power chair after the incident.	F 323	F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a residents's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Residents affected: Resident #24 has been discharged. Residents potentially affected: All residents have the potential to be affected by this cited practice. 100% weights on all residents have been obtained and reviewed for variances. Systemic measures: Residents are weighed on (re)admission x 4 weeks and thereafter monthly. Residents will be reviewed at the weekly at risk meeting and if needed interventions will be implemented. Residents with significant weight loss will be reviewed weekly x 4 weeks or until stable. Restorative nurse reviews weights and advises the DON/designee. Interventions are implemented and resident is reviewed in the weekly at risk meeting. Monitoring Change: The DON/designee will review weight audit tool weekly X 8 weeks then monthly. Concerns will be addressed when identified and reported to the QA committee monthly.	3/31/2011	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accurate assessment, monitoring, and notification to the physician of a significant weight loss for one resident (#24) of twenty-six residents reviewed. The findings Included: Resident #24 was admitted to the facility on June 14, 2010, with diagnoses including Vascular Dementia and Hypertension, and was discharged	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380		
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F 325	<p>Continued From page 21 to another facility on August 5, 2010.</p> <p>Medical record review of the Nutritional Risk Review dated June 18, 2010, revealed the resident was admitted on June 14, 2010, with a weight of 167 lbs (pounds), ate 75% (percent) of meals, had chewing problems, was a high risk for Malnutrition/Weight Loss and, "...does have a chewing & swallowing problem AEB (as exemplified by) need for mechanical soft diet. Appetite good, Weight WNL (within normal limits)..."</p> <p>Medical record review of the Monthly/Weekly Weight Recap Sheet, Weekly NAR (Nutritional at Risk) Review/Minutes, and Interdisciplinary Progress Notes dated July 8, 2010, revealed "...Current wt (weight) 160 stable...Supplements: Milk x (times)3. Triggers for review: Weekly Weights...Nut'l (increased) Risk...Related to: dc (discontinue) weekly...Interventions: Special Nutrition Program 2 cal/ml (calories/milliliter) med (medication) pass 2 oz (ounces) Qid (four times a day)...IDT (Interdisciplinary team) mfg (meeting) held R/ (resident) stable X4 wks (times 4 weeks) & (change) to monthly..."</p> <p>Medical record review of the Monthly/Weekly Weight Recap Sheet revealed, "Licensed Nurse must report to the Physician weight loss that meets the following criteria: 5% or more in one month 7.5% or more in 3 months 10% or more in 6 months or weight gain that is clinically adverse. Please Note: If a significant weight variance is recorded, weekly weight checks should be Initiated for 2 weeks to monitor for change of condition..."</p> <p>Medical record review of the Monthly/Weekly</p>	F 325			

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F 325	<p>Continued From page 22</p> <p>Weight Recap Sheet, Weekly NAR (nutrition at risk) Review/Minutes, and Interdisciplinary Progress Notes dated June 17, 2010, revealed the resident weighed 167 pounds and was to have weekly weights.</p> <p>Medical record review of the Monthly/Weekly Weight Recap Sheet, Weekly NAR Review/Minutes, and Interdisciplinary Progress Notes dated June 24, 2010, revealed "...Current wt (weight) 162.5 (down) 4 1/2. Supplements: milk x 3 (three times a day). Triggers for Review: Weekly Weights...Related to: No straw use chin tucks...conti (continue) to monitor..."</p> <p>Medical record review of the Monthly/Weekly Weight Recap Sheet, Weekly NAR Review/Minutes, and Interdisciplinary Progress Notes dated July 1, 2010, revealed the resident weighed 157 lbs and was re-weighed for a weight of 158 lbs. Further review revealed, "...Current wt 158 (down) 4 1/2# (pounds) 5.39% (percentage of weight loss)...Triggers for Review: Weekly Weights...Nut'l (nutritional) (increased) Risk...Interventions: 2 cal/ml (calories per milliliter) med pass 2 oz (ounces every) Qid (four times a day)..."</p> <p>Medical record review revealed weekly NAR and IDT meetings were stopped after the July 8, 2010, meeting and no further documentation was completed in the NAR or Interdisciplinary Progress Notes. Medical record review of the Monthly/Weekly Weight Recap Sheet revealed the resident weighed 159 lbs week 3 of July, 2010 and 154 lbs week 1 of August, 2010.</p> <p>Medical record review of a Dietary Progress Note dated July 7, 2010, revealed, "...PO (oral or by</p>	F 325			

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F 325	Continued From page 23 mouth) intake ~ 75% (approximately). Refuses snacks at HS (bedtime)...Admit wt (weight): 167# CBW (current body weight): 162.5# (down) 4.8# x 3 wks (times 3 weeks)...add milk c/ (with) each meal to add extra calorie/ pro. (Protein). Will monitor." Medical record review and interview with the Dietary Manager on March 2, 2011, at 9:50 a.m., and 10:25 a.m., in the Training Room, confirmed the facility's protocol was to weigh residents on admission for four consecutive weeks. Continued medical record review and interview confirmed residents who were losing weight during the four weeks were to be weighed weekly until a stable pattern had been established. Continued medical record review and interview confirmed the resident had not established a stable pattern of weights when the weekly weights and NAR meetings were discontinued. Continued medical record review and interview confirmed the resident was exhibiting a weight loss trend and continued to lose weight after the weekly meetings had been discontinued and the weight loss protocol had not been followed. Medical record review and interview with LPN #2 (Licensed Practical Nurse) on March 2, 2011, at 10:30 a.m., in the Training Room, confirmed the resident had experienced a weight loss, the facility had failed to continue to monitor the resident's weight loss, and there was no documentation the physician had been notified of the resident's weight loss.	F 325	F 514 RES RECORDS- COMPLETE/ACCURATE, ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Residents affected: Resident # 9, #20 were assessed by NP. Residents potentially affected: All residents have the potential to be affected by this cited practice. Licensed nurses were educated on protocol for medication administration with documentation. Systemic measures: DON/Designee will validate orders written and compare them to the current MAR to ensure medication is available and documented throughout the week. The SDC will coach and mentor nurses requiring additional training on medication administration and documentation with written competency completed. Monitoring change: The SDC will conduct med pass audit tool weekly x 4 weeks then monthly x 2 months and quarterly thereafter. The DON/Designee will receive notification of nurses requiring additional training by the SDC and report concerns to the monthly QA committee.	3/31/2011	
F 514 SS=D	C/O #26535 483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514			

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F 514	<p>Continued From page 24</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was complete for two (#9, #20) of twenty-six residents reviewed.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on January 15, 2010, with diagnoses including Vitamin B12 Deficiency, Cerebral Atherosclerosis, Vascular Dementia, Insomnia and Anxiety.</p> <p>Review of the Nurse Practitioner's (NP) orders dated November 9, 2010, revealed, "...Lortab 2.5/500 mg. (Milligrams) p.o. (by mouth) (for abdominal discomfort)...D/C (discontinue) Tylenol BID (two times a day) when Lortab available..."</p> <p>Review of the Medication Record for November 2010 revealed the resident received the Tylenol 650 mg. two times a day as ordered through November 15, 2010. Continued review of the</p>	F 514		

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F 514	<p>Continued From page 25</p> <p>November 2010 Medication Record revealed the resident did not receive the Lortab 2.5 mg. as ordered from November 9, thru November 15, 2010, as indicated by an "X" or by the nurse signing and circling the times as "not administered" to the resident. Continued review of the back of the Medication Record revealed no documentation why the Lortab was not administered on November 9, 10, or 11, 2010 (spaces were left blank).</p> <p>Resident #20 was admitted to the facility on November 18, 2010, with diagnoses including Alcohol Induced Persisting Dementia, Psychosis, Altered Mental Status, and Vertigo.</p> <p>Medical record review of the physician's recapitulation orders dated November 18-30, 2010, revealed the resident was to receive Thiamine (vitamin B1) 100 mg one tablet daily.</p> <p>Medical record review of the November 18-30, 2010, Medication Record revealed no documentation indicating if the Thiamine was administered on November 22, 23, 24, 25, 28, 29, and 30, 2010.</p> <p>Interview on March 2, 2011, at 10:00 a.m., with LPN #1, at the nursing station, confirmed the Medication Record was not complete and did not indicate if the Thiamine was administered on November 22, 23, 24, 25, 28, 29, and 30, 2010.</p>	F 514		